



# Partners in Care

New Mexico • Fall 2011



## Molina Healthcare New Mexico, Inc. (Molina Healthcare) & Project ECHO™ (Extension for Community Healthcare Outcomes)

*Delivering specialty access to your desktop.*

### What is Project ECHO™?

Project ECHO™ is an innovative telemedicine program developed to help primary care practitioners treat chronic and complex diseases in rural and underserved areas of New Mexico. You will become an expert in your area(s) of interest and obtain the support of a multi-disciplinary panel of experts via your desktop.

### What does the Molina Healthcare/Project ECHO™ partnership mean for you?

- **\$1500** Molina Healthcare scholarship to attend Project ECHO™ training in Albuquerque (Includes **FREE** webcam and installation);
- **\$50** Reimbursement to practitioners for each presentation (Molina Healthcare Members only) to any of the Project ECHO™ clinics;
- Access to nine (9) different multidisciplinary Project ECHO™ clinics such as Chronic Pain, Asthma and Diabetes; and
- AMA PRA Category 1™ Continuing Medical Educations credits.

### Interested in attending one of the upcoming Project ECHO™ Trainings?

- September 14, 2011
- September 28, 2011
- October 12, 2011
- October 26, 2011
- November 16, 2011
- November 20, 2011

Call toll free for more information or to register: (800) 377-9594 Ext. 180924. Visit the Project ECHO™ website <http://echo.unm.edu/>

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## Your Opinion Matters....Molina Healthcare Listens!

**How?** Molina Healthcare is improving our Provider Web Portal.

**When?** The first phase of these improvements is scheduled for September 2011. Web Portal Improvements include a more convenient, easier to use and more efficient portal.

**What?** The first phase of Molina Healthcare's will be released in September, and includes:

- Member Eligibility Verification:
  - More details about the Member provided, such as language(s) spoken and/or ethnicity;
  - Easier search functions for Members – all fields now show on the screen;
  - Quicker member search – new alert bar allows for quick verification;
  - New search options to narrow your search; and
  - Search today's date, or a previous date;
- Missed Services List (preventive services needed for Members, but not yet received) for primary care practitioners (PCPs):
  - View list of preventive services the Member has missed and needs to obtain.
- Claims or Service Request/Authorization:
  - Ability to submit claim or service request/authorization from the Member eligibility details page.

**The improved portal is easier, provides more options and is more convenient and efficient.**

**More?** Web Portal improvements will be coming this November, and even more in early 2012:

- November Improvements:
  - Full 5010 compliance;
  - Service request/authorization redesign;
  - Redesigned on-line Provider Directory;
  - Additional claim status information; and
  - Redesigned PCP roster with additional filter/search capabilities.
- 2012 Improvements:
  - Additional Claim Processing improvements;
  - HEDIS Reporting and Scorecards;
  - Improved benefit information; and
  - Much more...

Please contact your Provider Service Representative for additional information toll free at (800) 377-9594.



## Access to Primary Care Practitioner (PCP)

A Contracted Primary Care Practitioner (PCP) must ensure that he/she will be available or accessible, or arrange to have another qualified medical professional available or accessible twenty four (24) hours a day, seven (7) days a week.

The following are acceptable and unacceptable telephone arrangements for contracted PCPs after their normal business hours:

### Acceptable after-hours coverage

- All calls answered by an answering service must be returned within thirty (30) minutes;
- The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served, directing the patient to call another number to reach the PCP or another practitioner designated by the PCP;
- Someone must be available to answer the designated practitioner's telephone. Another recording is not acceptable; and
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within thirty (30) minutes.

### Unacceptable after-hours coverage

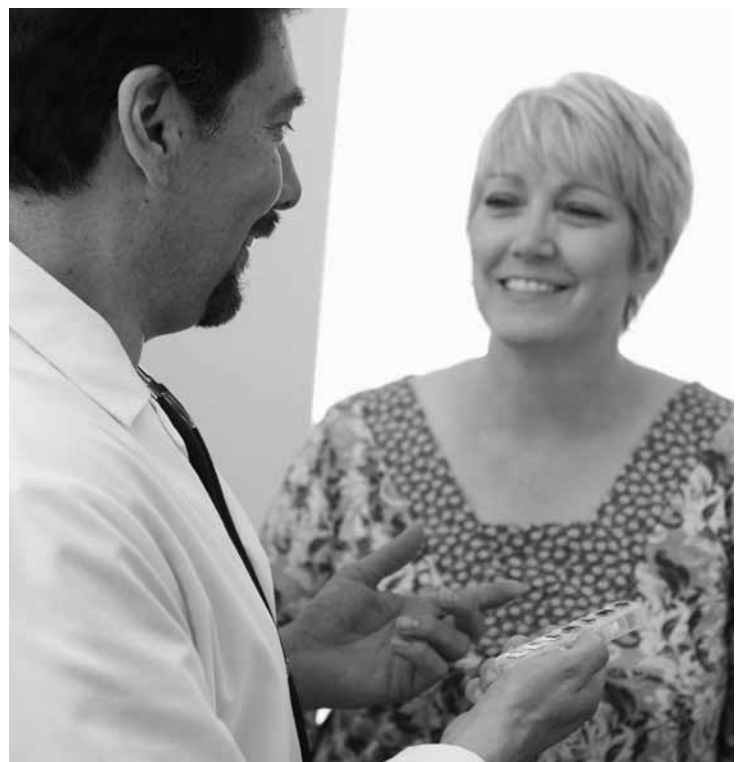
- The office telephone is only answered during office hours;
- The office telephone is answered after-hours by a recording that tells patients to leave a message;
- The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; or
- Returning after-hours calls outside of thirty (30) minutes.

## Access to all Practitioners/Providers

All practitioners/providers should follow the Access to Care Standards listed below. These standards are based on regulatory and accreditation standards. Molina Healthcare monitors compliance to these standards.

### Appointment Availability/ Waiting Times for Appointments

- **PCP: Routine symptomatic** exams should be provided within fourteen (14) days of the request;
- **Specialist: Routine asymptomatic** exams should be provided within twenty-one (21) days of the request;
- **Preventive Care – Asymptomatic** should be provided within thirty (30) days;
- **Urgent** care should be received within twenty-four (24) hours of the request; and
- **Emergency** care should be received immediately.



## Managing Influenza and Pregnancy

Influenza is a common topic during this time of year. The severe influenza seasons of the past and not too distant pandemic highlights the importance of promoting the influenza vaccine and good hygiene etiquette to your patients annually. Although it is important for all persons six (6) months and older to be protected by getting the influenza vaccine, particular emphasis should be put on those at high risk, especially women who are pregnant.

Pregnancy can add a layer of complexity when treating influenza. It is important to keep some key points in mind when managing your pregnant patients:

- **Encourage influenza vaccinations.** Pregnant patients that get influenza are at high risk for complications, so encourage vaccination regardless of trimester;

- **Treat influenza-like illness quickly.** Antiviral medications should be used as soon as possible to treat influenza-like illness. Educate your pregnant patients and staff on the signs and symptoms to look for. Establish procedures with staff to ensure early treatment after onset of symptoms;
- **Treat fever.** Fever can increase risk for certain birth defects. Acetaminophen is the recommended treatment for fever in pregnancy; and
- **Keep updated with current treatment recommendations.** Recommendations may change, so it is important to watch for updates regularly. For the most updated information on influenza, visit the Centers for Disease Control and Prevention (CDC) at <http://www.cdc.gov/flu/professionals/>.

*For more information on pregnancy and influenza, a prenatal toolkit is available on the CDC website at: [http://www.cdc.gov/flu/pdf/freeresources/pregnant/2011\\_influenza\\_prenatal\\_toolkit.pdf](http://www.cdc.gov/flu/pdf/freeresources/pregnant/2011_influenza_prenatal_toolkit.pdf)*

*Source: Responding to Influenza: A Toolkit for Prenatal Care Providers, [http://www.cdc.gov/flu/pdf/freeresources/pregnant/2011\\_influenza\\_prenatal\\_toolkit.pdf](http://www.cdc.gov/flu/pdf/freeresources/pregnant/2011_influenza_prenatal_toolkit.pdf)*



## HEDIS® and CAHPS® Results

Your patient's health is important to Molina Healthcare of New Mexico, Inc. (Molina Healthcare) and measuring the quality of the services our Members receive is also important to us. Molina Healthcare uses the Healthcare Effectiveness Data and Information Set (HEDIS®) measurement set from the National Committee for Quality Assurance (NCQA). Using this standard measurement set allows us to compare our results with similar plans across the country. In 2011, our HEDIS® results show improvements in the following areas:

- Childhood Immunizations;
- Well Child Care;
- Access to Care Child Visits;
- Appropriate Medications Usage for Asthma five (5)-eleven (11) year olds;
- Spirometry testing in the assessment and diagnosis of chronic obstructive pulmonary disease (COPD);
- Breast Cancer Screening;
- Cervical Cancer Screening;
- Chlamydia Screening;
- Cholesterol Testing;
- Monitoring Hypertension;
- Dilated Eye Exam for the Diabetic;
- Postpartum Visits and Frequency of Prenatal Visits; and
- Imaging Studies for Low Back Pain.

Our overall result also tells us we need to focus with you in improving other areas. Areas that Molina Healthcare in collaboration with Molina Healthcare practitioners/providers needs to focus on include:

- Appropriate Treatment of Upper Respiratory Infection;
- Avoidance of Antibiotics in the Treatment of Bronchitis;
- Nephropathy Testing for the Diabetic; and
- Timeliness of Prenatal Care.

Another way we measure quality is through surveys. Every year we send out the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This

survey asks questions about the Member's health care and the services they get through Molina Healthcare practitioners/providers. In 2011 our CAHPS® results show improvements in the following areas:

- Customer Service;
- Getting Needed Care;
- Rating of Personal Doctor;
- Shared Decision Making (with their provider);
- Health Promotion and Education (by provider); and
- Advising Smokers/Tobacco Users to Quit (by provider).
- Areas that Molina Healthcare needs to work on include:
- Overall Rating of Health Plan;
- Rating of All Health Care;
- Getting Needed Care;
- Getting Care Quickly;
- Rating of Specialist Seen Most Often;
- How Well Doctors Communicate (with patients); and
- Coordination of Care (by provider).

A summary of Molina Healthcare's 2011 HEDIS® and CAHPS® results can be found on our web site [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

To learn more or to request a copy of our current HEDIS or CAHPS results, call our Health Information Hotline toll free (800)377-9594, ext. 182618.

### Monitoring Our Quality Improvement Performance

The Molina Healthcare Quality Improvement Program (QIP) is a comprehensive framework for continuous assessment and focused improvement of all aspects of health care delivery and service. We annually assess the effectiveness of our QIP in order to determine our success and opportunities for improvement. One of our primary goals is to help you take care of your patients (our Members) and their families. Our QIP goals for 2011 include:

- Design and maintain programs that improve the care and service outcomes and ensure patient safety;

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## HEDIS and CAHPS Results *Continued...*

- Using feedback from stakeholders, improve reporting methods to enhance the availability of relevant and timely information;
- Use a multidisciplinary committee structure to facilitate the achievement of QIP goals, improve organizational communication and ensure participation of contracted community practitioners in clinical aspects of programs and services;
- Facilitate organizational efforts to achieve, maintain and enhance regulatory compliance, including NCQA accreditation and to continually review practices to ensure compliance with standards and contractual requirements;
- Promote and collaborate with the strategic health care entities in the development and implementation of Patient Centered Medical Homes and Accountable Care Organizations
- Ensure systems are in place to address the cultural and linguistic diversity found within Molina Healthcare's Membership; and
- Ensure systems are in place to address the complex health needs found within Molina Healthcare's membership.

While some of these goals focus on improving the way we do our jobs at Molina Healthcare, they still point to our main goal – to improve the quality of care and

service to our Members. In addition to providing the best possible care to our Members, our primary quality objective in 2011 is maintaining “Excellent” NCQA accreditation. This objective is maintained through our accreditation process as well as our HEDIS and CAHPS results. Some areas that we have identified as focused initiatives for 2011 include:

- Identify and implement HEDIS improvement targeted activities to encourage Members to receive appropriate and timely care;
- Identify and implement CAHPS activities that will enhance the Member's understanding of their benefits and how manage care can actively work for them;
- Maintain “Excellent” NCQA accreditation; and
- Enhance patient safety initiatives and communicate to our Members ways to effectively ensure their own safety within the health care setting.

Many of Molina Healthcare's positive changes are also shown in our HEDIS and CAHPS results. We also promote best practice initiatives and provide an array of tools for you and your practice. To learn more about our QIP initiatives or to request a copy of our current QIP plan results, call our Health Information Hotline toll free (800) 377-9594, ext. 182618 or visit the QIP section within our web site at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

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## Nurse Advice Line

The Nurse Advice Line is here to help. Trained nurses are available to serve your patients twenty-four (24) hours a day, seven (7) days a week. If your patients have any concerns about their health, our specially trained triage nurses are available to listen to their symptoms, provide medical advice and make referrals to an appropriate care setting. Encourage your patients to call our Nurse Advice Line for assistance.

### Salud and SCI Members

Toll free Nurse Advice Line: **(888) 275-8750 (English)**  
**(866) 648-3537 (Spanish)**

### UNM SCI Members

Toll free Nurse Advice Line: **(877) 725-2552**

For the hearing impaired please call toll free: **TTY: (866) 735-2929 (English)**  
**TTY: (866) 833-4703 (Spanish)**

## HIPAA 5010 – Time Is Running Out

In a previous provider article, Molina Healthcare discussed the major changes coming down the pike under Health Insurance Portability and Accountability Act (HIPAA): *the migration to the HIPAA 5010 transactions and the ICD-10 code sets*. With a compliance deadline of January 1, 2012, the clock is ticking and time is running out for practitioners/providers and health plans to complete their migration to the 5010 standards.

### Where Should We Be In Our 5010 Migration Plan?

All practitioners/providers, trading partners and health plans should be aggressively pursuing Level II compliance, which means completing end-to-end testing with their partners. For practitioners/providers this means you should be working with your electronic claim transaction clearinghouse partner to make sure they are performing 5010 testing on your behalf. For health plans and trading partners this means that you should be directly testing with all trading partners and business associates.

### What Is The Migration Process For Moving a Provider, Trading Partner or Business Associate to 5010?

The HIPAA 5010 compliance requirements dictate that all covered entities must be exchanging 5010 transactions as of January 1, 2012. However, it is allowable for any covered entity that has finished 5010 testing to start exchanging 5010 transactions immediately upon completion of successful testing (requires agreement between the entities exchanging 5010 transactions). For health plans it is desirable to move partners to a 5010 production status upon successful testing in order to prevent a huge backlog of activity in the 4<sup>th</sup> quarter of 2011. From a HIPAA perspective, both the 4010A1 and 5010 transaction standards are allowable for use during the period of March 17, 2009 through December 31, 2011.

### What Does Dual Use Mean?

Many practitioners/providers have mentioned to Molina Healthcare that they have heard the term “dual use” mentioned and are unclear as to what this means. Dual Use means that for a given transaction, both the 4010A1 and 5010 version of that transaction are supported in production. As an example, Molina Healthcare currently has the 835 outbound (payment, remittance advice) transaction in a dual use mode. This means that Molina Healthcare can send a business associate or other partner either a 4010A1 or 5010 version of the 835 transaction based on the business agreement between these two entities. Molina Healthcare will move all transactions into a dual mode status as each transaction is ready for 5010 production.

### What Should a Provider Do To Prepare For 5010?

- Visit the Centers for Medicare and Medicaid Services (CMS) and Workgroup for Electronic Data Interchange (WEDI) websites to obtain education material on the 5010 standard;
- Contact your practice’s software vendors to find out if they are upgrading their software to support 5010 compliance;
- Upgrade your practice management and other software as required to a 5010 compliant version;
- Conduct internal software testing to verify that you can properly send and receive 5010 transactions;
- If you use a healthcare clearinghouse to send and/or receive 5010 transactions, contact your clearinghouse account representative to confirm that they are 5010 compliant and make arrangements to start testing; and
- If you exchange 5010 transactions directly with any health plans, confirm that the plan is Level I 5010 compliant and contact them to initiate external testing of the 5010 transactions.

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## HIPAA 5010 – Time Is Running Out *Continued...*

### Molina Healthcare's 5010 Readiness

Molina Healthcare has achieved Level I compliance and extensively involved with Level II external partner testing. Molina Healthcare is currently testing inbound and outbound 5010 transactions with clearinghouses, business associates and state and federal trading partners. Molina Healthcare has moved several 5010 transactions into a dual use mode. For additional information regarding Molina Healthcare's 5010 migration plans, please visit our website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)

## MEDICAL RECORD REVIEW

Molina Healthcare of New Mexico, Inc. (Molina Healthcare) is committed to improving the health care of our Members. One of the ways we work to accomplish this is to establish standards for medical record documentation. Medical record standards promote quality of care through:

- Communication, coordination and continuity of care; and
- Efficient and effective treatment.

To determine our compliance with these established standards Molina Healthcare participates in and conducts various audits throughout the year. Based on the results of our most recent state compliance audit assessment the following issues were identified as opportunities for improvement:

- **Documentation of allergies and adverse reactions** (*common documentation areas include, but are not limited to, encounter note, problem list & medication history*). *Audit findings: Some records did not have allergies or adverse reactions clearly documented or were left blank.*
- **Documentation of preventive services/risk screening, including history of smoking, alcohol use and substance abuse for members twelve (12) years of age and older** (*common documentation areas include but are not limited to, encounter note and medical history*). *Audit findings: Some records did not have history of smoking, alcohol use or substance*

*abuse clearly documented or a designated section to document this type of history.*

- **Advance directives for adults eighteen (18) years of age and older** (*a notation must be made in the record that the member either has an advance directive or has been offered information regarding having advance directives*). *Common documentation areas include but are not limited to, encounter note and medical history. Audit findings: A large percentage of records did not have any advance directives information documented.*

For practices utilizing Electronic Medical Record (EMR), it is crucial that these elements are included in the program.

These elements are commonly accepted standards for documentation in medical records, as well as being required by various regulatory entities. To facilitate improvement during the next year, nurses from our Quality Improvement Department will be conducting documentation audits and providing education to various practitioners throughout the state.

If you would like more information regarding medical record standards, please call the Quality Improvement Department toll free at (800) 377-9594, ext. 182618.

## 2011 Provider Satisfaction Survey Report - Molina Healthcare of New Mexico, Inc.

### *Your Opinions Matter...*

Thanks to all of those who took time out of their busy schedules to respond to the 2011 Molina Healthcare of New Mexico, Inc. (Molina Healthcare) Provider Satisfaction Survey. The survey was conducted from April through June 2011. A total of one hundred sixty-one (161) surveys were completed this year (seventy [70] mail & ninety-one [91] telephone).

Molina Healthcare utilizes the report results to develop opportunities for improving and maintaining provider satisfaction. Your opinion is important. Please contact your dedicated Provider Service Representative toll free (800) 377-9594 with suggestions on improving our service.

The chart below presents 2011 Summary Rate Scores for Molina Healthcare's composites and overall satisfaction attributes. In the survey, respondents were asked to rate Molina Healthcare and All Other Plans in which they participate. A comparison between these scores is displayed in this chart. In addition, results from previous studies and the 2010 The Myers Group (TMG) Book of Business (B.O.B.) Benchmark is also provided for comparison.

Composites/ Attributes	Summary Rate Definition	2011 Summary Rate Scores		Molina Healthcare Trend Data Summary Rate Scores				TMG 2010 BoB Summary Rate
		Molina Healthcare	All Other Plans	2008	2009	2010	2011	
Customer/Provider Services <sup>1</sup>	Excellent Or Very Good	34.1%	31.5%	33.6%	42.7%	36.3%	34.1%	NA
Network		31.7%	30.5%	33.2%	42.2%	33.9%	31.7%	35.7%
Coordination of Care		29.7%	NA	NA	43.6	32.0%	29.7%	NA
Utilization Management		25.6%	20.3%	26.8%	37.0%	24.1%	25.6%	NA
Quality Improvement		27.4%	24.1%	27.3%	39.5%	28.3%	27.4%	NA
Claims/Finance Issues		28.4%	25.6%	26.0%	44.0%	31.5%	28.4%	NA
Pharmacy		19.0%	16.1%	17.5%	30.0%	17.5%	19.0%	NA
Credentialing		29.3%	27.9%	26.7%	44.6%	33.8%	29.3%	NA
<b>Overall Sat Composite</b>		<b>81.2%</b>	<b>NA</b>	<b>83.3%</b>	<b>85.7%</b>	<b>77.1%</b>	<b>81.2%</b>	<b>80.5%</b>
Recommend to other patients	Definitely Probably Yes	87.0%	NA	88.4%	84.5%	81.0%	87.0%	83.0%
Recommend to other physicians		87.0%	NA	87.4%	83.7%	80.6%	87.0%	83.3%
Overall Satisfaction	Very Somewhat	69.6%	77.6%	81.4%	81.7%	69.6%	69.6%	75.1%

The 2010 TMG Medicaid B.o.B. is a benchmark containing data from all eligible Provider Satisfaction Surveys for which TMG collected data in 2010. The benchmark includes data from all thirty-six (36) plans encompassing ten thousand and eight (10,008) respondents.

## ICD-10 Introduction and Implementation Project

### ICD-10 CM and PCS – What is That?

With all of the highly publicized changes underway in healthcare due to the Health Care Reform bill (Patient Protection and Affordable Care Act of 2010); it is easy to overlook the less high profile, but still major change coming down the pike under HIPAA: the ICD-10 code sets. With a compliance deadline of October 1, 2013, the clock is ticking for covered entities including providers, vendors, clearinghouses and health plans to complete their conversion to the ICD-10 code sets.

Why is it required to switch from ICD-9 codes to ICD-10 codes? The health care industry has been using ICD-9 codes for nearly 30 years and they just have not been able to keep up with the changes in medicine, the newer conditions and with the newer ways of treating patients. The ICD-10 diagnosis code set has been designed to capture much more specific information on the patient's diagnosis. The procedure code set will enable hospitals to record much more specific information on procedures performed and devices used.

#### **What is ICD-10 and how does the change impact healthcare providers?**

The ICD-10-CM diagnosis code set includes significant improvements over the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM). There are currently approximately 14,000 ICD-9 diagnosis codes compared to over 69,300 ICD-10 diagnosis codes.

The ICD-10-PCS Procedure Coding System provides detailed codes to describe complex medical procedures for use on inpatient hospital claims at a much more granular level than its ICD-9 counterpart. There are currently approximately 3,800 ICD-9 institutional procedures codes compared to nearly 72,000 ICD-10 institutional procedures codes (PCS). ICD-10-PCS will not be used on physician claims, even those for inpatient visits. The Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) will continue to be the code sets for reporting ambulatory procedures.

As HIPAA covered entities, providers, their vendors and clearinghouses must convert to the new ICD-10 code sets for claims and/or encounters submission with dates of services or date of discharge on or after October 1, 2013.

#### **What Should a Provider Do To Prepare For ICD-10?**

- Visit the CMS websites to obtain education material on the ICD-10 mandate
- Contact your practice's software vendors to find out their approach and timeline to support ICD-10 compliance;
- Conduct internal assessments across people, process and technology to determine impacts and level of effort required;
- Collect information from each department on current use of ICD-9 and the number of staff members who need ICD-10 resources and training. Staff training will most likely involve billing and other financial personnel, coding staff, clinicians, management, and IT staff
- If you use a healthcare clearinghouse to send claims and/or encounters, contact your account representative to confirm that they are 5010 compliant and will be able to submit ICD-10 compliant transactions on your behalf; and
- If you submit claims directly with any health plans, confirm what the plan's timeframe and testing approach will be and contact them to initiate that dialogue.

#### **What are the benefits to this code set change?**

On the administrative side, the codes provide more information on the claim. There should be less need to request additional information from our providers to make payment decisions, so claims adjudication for this purpose should not be delayed.

With the greater specificity of ICD-10-CM diagnoses and ICD-10-PCS procedure codes, claims information can be used for data capture and analysis.

Pay for performance and provider quality measurement are key drivers in today's health care world. Many of the measures used for these efforts are based on specific diagnoses. With ICD-10, we have an opportunity to develop more targeted and more accurate quality measures, since we have better diagnosis information. This also gives us the opportunity to improve quality measurement and pay for performance, which should lead to better quality health care for our members

#### **Molina Healthcare's ICD-10 Readiness**

Molina Healthcare has completed an enterprise-wide detailed impact assessment and has conducted initial surveys with our trading partners, business associates, vendors and providers. Timeline and important information will be shared in the near future. Be on the lookout for additional information in subsequent newsletters.

# Medicare Section

## A Clinical Concern for Older Patients: Anticholinergic Medication Use Linked to Cognitive Impairment and Higher Mortality

A recent study has found that anticholinergic medications, many of which are commonly used to treat multiple conditions in the older population, may increase the risk of cognitive impairment and death in older adults. The study assessed prescription and over the counter (OTC) medications in over twelve thousand (12,000) men and women over the age of sixty-five (65).

The results of the study were:

- Forty-eight percent (48%) of patients reported taking medications with anticholinergic properties;
- For those patients significantly cognitively impaired at baseline, mortality was strongly related to a higher anticholinergic side effect profile;
- For patients with higher anticholinergic side effect profiles, higher cognitive impairment was found at baseline, as well as greater cognitive decline at re-measurement; and
- Higher risk of mortality was found for patients taking anticholinergics with higher side effect profiles, with odds increasing twenty-six percent (26%) for each additional side effect ranking point.

**The results of this study highlight the importance of regular review of older patients' medications.** In light of these findings, it is also important to emphasize that **Molina Medicare has services to help support you in the management of your Molina Medicare Members.** Molina Medicare's Pharmacy Department has a medication therapy management program<sup>1</sup> in which our pharmacists complete a clinical assessment with your patients. We will work with you regarding medications (such as evaluating at-risk medications, above) and compliance. Please contact the department for assistance and additional information.

**Molina Medicare has additional resources to assist you and your patients:**

- Toll free pharmacy line for practitioners/physicians: (888)562-5442, ext. 179787
- Molina Medicare website – Formulary, Prior Authorization, Step Therapy Criteria and more located at: [www.MolinaMedicare.com](http://www.MolinaMedicare.com)
- Disease Management programs for Asthma, Diabetes, COPD and Cardiovascular diseases, call toll free (866)891-2320 for more information

<sup>1</sup> Members must meet certain criteria for enrollment in the medication therapy management program.

## The Affordable Care Act and Medicare Star Ratings – The Provider’s Role

With the passage of the Affordable Care Act, the health care industry will be subject to greater scrutiny wherever taxpayer dollars are involved. One method of oversight is Medicare “Star Ratings.” Star ratings are not new, but in the current regulatory climate, value-based payment is receiving more focus.

### What are Star Ratings?

Star Ratings are a system of measurements Centers for Medicare and Medicaid Services (CMS) uses to determine how well practitioners/physicians and health plans are providing care to Medicare members. This system is based on nationally-recognized quality goals such as “The Triple Aim” and the Institute of Medicine’s “Six Aims,” focus on improving the health and care of your patients, safe and effective care and making care affordable. These aims are realized through specific measures, such as:

- Access to Preventive Care – are your patients getting in to see you at least once a year?
- Screenings:
  - Are your patients getting timely glaucoma screenings?
  - Are your diabetic patients’ annual (or more) HbA1c test results under nine percent (9.0%)?
- Patient survey questions – “...rate your satisfaction with your personal doctor.”

### What Can Practitioners/Physicians Do?

- Ensure your patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists such as ophthalmology;

- Review the HEDIS® preventive care listing of measures for each patient you see to determine if you have missed anything applicable to your patients’ age and/or condition;
- Check that your staff is properly coding all services you provide (see example below);
- Be sure your patients understand what they need to do.

Doing well on Star Ratings measures benefits both you and your patient. We are happy to help you take the next step.

*Example of HEDIS® CPT/ICD-9 code sheet you can use in your practice (also available at [www.MolinaMedicare.com](http://www.MolinaMedicare.com)):*

Comprehensive Diabetes Care - Age: 18-75 Years - Codes to Identify Diabetes	
Description	ICD-9-CM Codes
Diabetes	250, 357.2, 362.0, 366.41, 648.0
Codes to Identify Outpatient Visits	
Description	CPT Codes
Outpatient	92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
Codes to Identify HbA1c Testing	
CPT Codes	CPT Category II Codes
83036, 83037	3044F, 3045F, 3046F

Molina Medicare has additional resources to assist you and your patients. For access to tools that can assist you in your practice, please go to our Molina Medicare website at [www.MolinaMedicare.com](http://www.MolinaMedicare.com) and click on Providers. You will find a variety of resources, including:

- HEDIS® CPT/ICD-9 code sheet (as shown above);
- A list of HEDIS® & CAHPS® Star Ratings measures; and
- Article archive.

## Coordination of Care during Planned and Unplanned Transitions for Medicare Members

Molina Medicare is dedicated to providing quality care for our Medicare members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a Molina Medicare member is discharged from a hospital. By working together with providers, Molina Medicare makes a special effort to coordinate care during transitions. This coordination of specific aspects of the member's transition is performed to avoid potential adverse outcomes.

To ease the challenge of coordinating patient care, Molina Medicare has resources to assist you. Our Utilization Management nurses and Member Services staff are available to work with all parties to ensure appropriate care.

In order to appropriately coordinate care, Molina Medicare will need the following information in writing from the facility *within one business day* of the transition from one setting to another:

- Initial notification of admission within 24 hours of the admission
- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

**This information can be faxed to Molina Medicare at:**  
(888) 802-5711

To assist with the discharge planning of Molina Medicare members, please note the following important phone numbers:

- **Medicare Member Services & Pharmacy:** (866) 440-0127
- **Behavioral health** services and substance abuse treatment for Molina Medicare members can be arranged by contacting: (888) 825-9266 Option 3, 2

- **Transportation** services for Molina Medicare Options Plus Members may be arranged by calling **MTM at (866) 867-3208**
- The **Nurse Advice Line** is available to members 24 hours a day, 7 days a week at (888) 275-8750

### Important information you need to know about Molina Medicare Options Plus:

- All beneficiaries have rights that are defined in our provider manual. They are also available in the member EOC posted on our website at **www.MolinaMedicare.com**.
- Molina Medicare Options Plus members have Medicare and Medicaid benefits designed to meet their special needs, therefore the state agency or its designated health plans have the responsibility for coordinating care, benefits and co-payments. Please be aware of your patients' status & Medicaid benefits and bill the correct entity.
- Health plans and providers can never charge these members more than they would have paid under Original Medicare and Medicaid. Members can also call the Medicaid agency for details and have specific rights with regard to their Medicaid benefits.
- Providers are responsible for verifying eligibility and obtaining approval for services that require prior authorization as outlined in the Provider contract. Our Medicare Member Services department can assist you in this regard.

Please contact the UM Department at **or Medicare Member Services** if you have questions regarding planned or unplanned transitions at:

**UM Department:** (888) 825-9266 Option 3, 2  
**Member Services:** (866) 440-0127